

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Arlington	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 1806 N. Wayne Street	
3. NAME OF DECEASED (Type or Print) WILLIAM (First) (Middle) (Last) ALLEN		4. DATE OF DEATH (Month) (Day) (Year) February 8 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 10, 1907
9. AGE last birthday 43 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tele. Repairman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Company	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578-14-7181	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary Thrombosis due to		2 hrs.
Antecedent cause(s) (b) Coronary Sclerosis, severe		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis, generalized		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 12, 1951, to Feb. 8, 1951, and that death occurred at 3:10 AM, from the causes and on the date stated above.

SIGNATURE E. P. BRANNON, M.D.		DATE SIGNED 2-8-51	
Chief, Professional Services, VAH, Perry Point, Md.			
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-8-51	NAME OF CEMETERY OR CREMATORY Unknown	LOCATION (City, town, or county) Arlington, Virginia
DATE REC'D BY LOCAL REG. Feb. 8, 1951	REGISTRAR'S SIGNATURE Irene E. Daugherty	24. FUNERAL DIRECTOR	ADDRESS
		Perryman & Sons, Havre de Grace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1411

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1412 92

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) Reed	(Last) Andrew
4. DATE OF DEATH	(Month) Feb.	(Day) 5	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec. 16, 1873
9. AGE last birthday 77 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gardener & Carpenter
11. BIRTHPLACE (State or foreign country) Perryville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Andrew		14. MOTHER'S MAIDEN NAME Frances Riddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-01-0711A	
17. INFORMANT Mrs. Myrtle Acton			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
454x Immediate cause (a) Cardio Nephritis					
131a Antecedent cause(s) (b) Thrombosis of Iliac Arteries					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 24, 1951, to Feb 4, 1951, that I last saw the deceased alive on Feb 4, 1951, and that death occurred at 9:15 PM, from the causes and on the date stated above.					
SIGNATURE R. D. Jackson M.D.		(Degree or title)		ADDRESS Rising Sun Md. DATE SIGNED 2/5-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Feb 7, 1951		NAME OF CEMETERY OR CREMATORY West Nottingham	
LOCATION (City, town, or county) Near Colora, Md.		(State)			
DATE REC'D BY LOCAL REG. Feb 6		REGISTRAR'S SIGNATURE H. H. Hagen		24. FUNERAL DIRECTOR J. C. Tyson, Rising Sun, Md.	

930 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Washington, D. C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 1768 Lang Place, N.E.	
3. NAME OF DECEASED (First) OLIVER (Middle) A. (Last) BARNES		4. DATE OF DEATH (Month) February (Day) 8 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 24, 1910
9. AGE last birthday 40 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxicab Driver		10b. KIND OF BUSINESS OR INDUSTRY Private	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George H. Barnes		14. MOTHER'S MAIDEN NAME Glennie D. Exum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Uremia, Uremic poisoning due to		4 days
Antecedent cause(s) (b) Malignant Lymphoma, thoracic		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 26, 1951, to Feb. 8, 1951, that I saw the deceased alive on Jan. 26, 1951, and that death occurred at 11:35 AM m., from the causes and on the date stated above.

SIGNATURE E. P. SHALON, M.D.		DEGREE OR TITLE Chief, Professional Services, VAH, Perry Point, Md.		DATE SIGNED 2-9-51
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-10-51	NAME OF CEMETERY OR CREMATORY Church Cemetery	LOCATION (City, town, or county) Washington, D.C.	(State)
DATE REC'D BY LOCAL REG. Feb 10, 1951	REGISTRAR'S SIGNATURE Diana S. Hargrave	24. FUNERAL DIRECTOR L. E. MURRAY & SON, 1337 10th St. S.W. Wash. D.C. 682536		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County Elkton
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 57 years
 Hospital, institution, or street address where death occurred:
139 Collins St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 139 Collins St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Leola Bartonothus 3. (b) Social Security Number none

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Gaddius Bartonothus
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 11, 1893
 8. AGE: Year 57 Month 4 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Elkton, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business own home
 12. Name Levi Tilghman
 13. Birthplace Elkton Maryland
 14. Maiden name Susie Wilson
 15. Birthplace Elkton Maryland

16. Informant Helen L. Dennis
 Address 710 N. DeKalb St., Phila. Pa.

17. Burial 2/10/51
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Providence Cem.
 Location Elkton, Maryland

18. Funeral director Edmund Bell
 Address 909 Poplar St., Wilm. Del.

19. Feb 10 1951
 (Date rec'd by registrar) Registrar H. B. Fraser

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1951 at 5:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1950 to February 5 1951
 and that I last saw him alive on February 4 1951
 Immediate cause of death arterio-sclerosis
 DURATION 14/10/51
 Due to _____
 Due to _____
 Other conditions Chr. Myocarditis 1947
421.1 La Grippe 1/23/51
 (Include pregnancy within 3 months of death)
 92a Major findings of operations _____ Date of op. _____
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE James L. Johnson M.D.
 Address Elkton, Md. Date signed 2/10/51

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in 18 shown on:

FILM No. G 13 OFEB 14 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1415

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Echelon		LENGTH OF STAY (in this place) 27 hours		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elk Mills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Elmwood Hosp.				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) CHARLES BOSEMAN		(First) (Middle) (Last)		4. DATE OF DEATH 2 - 2 1951		(Month) (Day) (Year)	
5. SEX M.		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH 1-31-51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elk Mills Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Charles Boseman		14. MOTHER'S MAIDEN NAME Helen Virginia Van Den Heuvel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. —	
				17. INFORMANT AND ADDRESS Helen R. Van Den Heuvel			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Pneumonia and septicemia (2/13/51)			
Immediate cause (a) Infection due to 48 hours			
Antecedent cause(s) (b) Labor & infection of mother			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-31, 1951, to 2-2, 1951, that I last saw the deceased alive on 2-1, 1951, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE R. E. Dodson M.D.		(Degree or title)		ADDRESS Perryman Md.		DATE SIGNED 2-2-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 2-3-51		NAME OF CEMETERY OR CREMATORY Methuena		LOCATION (City, town, or county) (State) Cherry Hill, Cecil Md.	
DATE REC'D BY LOCAL REG. Feb 3		REGISTRAR'S SIGNATURE H. H. Trager		24. FUNERAL DIRECTOR Joseph A. Evans North East Md.		ADDRESS	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) J (First) (Middle) Walton (Last) Campbell		4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-15-1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant, Retired		10b. KIND OF BUSINESS OR INDUSTRY General Supply	9. AGE last birthday 76 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Campbell		14. MOTHER'S MAIDEN NAME Elizabeth Longhurst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS M. Charlotte Campbell, Port Deposit	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION Md.	INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause (a)	Pulmonary Congestion		2 days
Antecedent cause(s)	(b) Left Heart Failure -		6 months
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	Arteriosclerosis		5 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov-20, 1950, to Feb 26, 1951, that I last saw the deceased alive on Feb 26, 1951, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE E. J. Benson, M.D.		ADDRESS Port Deposit, Md.		DATE SIGNED 2/28/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 3-1-1951		NAME OF CEMETERY OR CREMATORY Hopewell	
LOCATION (City, town, or county) (State) Port Deposit, Md. Rural		24. FUNERAL DIRECTOR Lee A. Patterson & Son			
DATE REC'D BY LOCAL REG. 2-28-1951		REGISTRAR'S SIGNATURE Irene E. Longhurst		ADDRESS Perryville, Md. 290646	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Charles H. DeMond

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1417 94

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
TOWN <u>North East</u>		TOWN <u>North East</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u>	(Middle) <u>H</u>	(Last) <u>DEMOND</u>
4. DATE OF DEATH	(Month) <u>2</u>	(Day) <u>23</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept 17 1861</u>
9. AGE last birthday <u>89</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Ret 1944</u>	11. BIRTHPLACE (State or foreign country) <u>North East md</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Joseph P. Demond</u>	14. MOTHER'S MAIDEN NAME <u>Caroline Bullen</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>Mrs. Ida Cameron</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
442x Immediate cause (a) <u>Gastric Hemorrhage</u>			<u>3 weeks</u>
61 Antecedent cause(s) (b) <u>Hypertensive Arteriosclerotic Cardiovascular Renal Disease</u>			<u>5 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May, 1946, to 23 Feb, 1951, that I last saw the deceased alive on 22 Feb, 1951, and that death occurred at 2:10 P.m., from the causes and on the date stated above.

SIGNATURE <u>Klaus H. Huchner</u>	(Degree or title) <u>M.D.</u>	LOCATION (City, town, or county) <u>North East Md</u>	DATE SIGNED <u>26 Feb '51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-27-51</u>	NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	LOCATION (City, town, or county) <u>North East md</u>
DATE REC'D BY LOCAL REG. <u>2-27-51</u>	REGISTRAR'S SIGNATURE <u>Sarah E. Kothermel</u>	24. FUNERAL DIRECTOR <u>Joseph R. Shaw</u>	ADDRESS <u>North East md</u>

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1418

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elk Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>CATHERYN</u>	(Middle)	(Last) <u>Dempsey</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct 22, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>West Grove, Pa.</u>
13. FATHER'S NAME <u>William Dempsey</u>		14. MOTHER'S MAIDEN NAME <u>Grace Chadwick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>William Dempsey</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Bronchial Pneumonia</u>	<u>3 days</u>	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c) <u>Infectious Diarrhea</u>	<u>24 hrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Feb, 1951, to 4 Feb, 1951, that I last saw the deceased alive on 3 Feb, 1951, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

SIGNATURE George J. Knud Jr. ADDRESS Elkton, Md. DATE SIGNED 2-4-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-6-51</u>	<u>Elkton Cemetery</u>	<u>Elkton Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 5</u>	<u>J. K. Traser</u>	<u>H. W. Poppin & Son</u>	<u>Elkton Md.</u>

20-204-1-17-2-40-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 1123 Congress Street, S.E.	
3. NAME OF DECEASED (Type or Print)	(First) CONRAD	(Middle) D.	(Last) ERNST
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 21, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Private	9. AGE last birthday 65 yrs.
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad B. Ernst		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. XXX-1	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Uremia, Uremic poisoning due to		48 hrs.
Antecedent cause(s) (b) Nephrosclerosis Severe due to		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis generalized, severe		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia, left lower lobe		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-12, 19 48, to 2-11, 19 51, that I last saw the deceased on 2-11-51, and that death occurred at 6:45 PM, from the causes and on the date stated above.

SIGNATURE E. P. BRANNON, M.D.		ADDRESS Chief, Professional Services, VAH, Perry Point, Md.		DATE SIGNED 2-12-51
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-12-51	NAME OF CEMETERY OR CREMATORY C	LOCATION (City, town, or county) C	(State)
DATE REC'D BY LOCAL REG. Feb. 12, 1951	REGISTRAR'S SIGNATURE Diana E. Langhorne	24. FUNERAL DIRECTOR PENNINGTON & SONS		ADDRESS Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1420
Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesapeake City, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural give location) <u>Biddle St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>E.</u>	(Last) <u>Foard</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 25/76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	9. AGE last birthday <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Chesapeake City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Mary E. Billany</u>	
13. FATHER'S NAME <u>Eli J. Foard</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Billany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT <u>Miss Fannie Foard Chesapeake City</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>acute Cardiac dilatation</u>	<u>10 minutes</u>
Antecedent cause(s) (b) <u>Coronary thrombosis</u>	<u>2 wks</u>
(c) <u>Cardio renal vascular disease</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 2, 1950, to Feb 4, 1951, that I last saw the deceased alive on Feb 3, 1951, and that death occurred at 2 A.m., from the causes and on the date stated above.

SIGNATURE <u>Wheeler Bates</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Elkton Md</u>	DATE SIGNED <u>2/4/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Feb. 7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Bethel</u>	LOCATION (City, town, or county) (State) <u>Near Chesapeake City, Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 6</u>	REGISTRAR'S SIGNATURE <u>FK Strayer</u>	24. FUNERAL DIRECTOR <u>H. W. Tippet & Son, Elkton, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1421 94

1. PLACE OF DEATH- COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CHARLESTOWN</u> LENGTH OF STAY (in this place) <u>30</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CHARLESTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIAM</u> (Middle)	(Last) <u>FREDERICK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>18</u> <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>3-22-1859</u>
9. AGE last birthday <u>91</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATED MACHINES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET 30YRS</u>	
11. BIRTHPLACE (State or foreign country) <u>PORT CHESTER NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CARL FREDERICK</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Helen Frederick</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Generalized Arteriosclerosis</u>	<u>10 years</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1946, to Feb, 1951, that I last saw the deceased alive on 18 Feb, 1951, and that death occurred at 9:45 P.m., from the causes and on the date stated above.

SIGNATURE Mans H. Hushur ADDRESS North East Rd DATE SIGNED 19 Feb 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>2-20-51</u>	NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW</u>	LOCATION (City, town, or county) (State) <u>WILMINGTON MD</u>
DATE REC'D BY LOCAL REG. <u>2-19-51</u>	REGISTRAR'S SIGNATURE <u>Sarah G. Rothermel</u>	24. FUNERAL DIRECTOR <u>Joseph P. Shaw</u>	ADDRESS <u>North East Rd</u>

690358

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 142295

1. PLACE OF DEATH COUNTY <u>Cecil</u> <u>Rising Sun Rural</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rising Sun Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rising Sun Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Franklin</u>	(Last) <u>Garvin</u>
6. SEX <u>Male</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 4, 1878</u>	9. AGE last birthday <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Rising Sun Md. Rural</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Benjamin Garvin</u>		14. MOTHER'S MAIDEN NAME <u>Susan Ferguson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Elwood Biggers Rising Sun, Md.</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>	<u>18 days</u>
Antecedent cause(s) (b) <u>Arterio - Sclerosis - Hypertension -</u>	<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<u>10 yrs.</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? <u>X</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Jan 29, 1951</u> , to <u>Feb 16, 1951</u> , that I last saw the deceased alive on <u>Feb 16, 1951</u> , and that death occurred at <u>4:45 P.m.</u> ; from the causes and on the date stated above.			
SIGNATURE <u>B. J. Pennew, M.D.</u>		ADDRESS <u>Port Deposit, Md.</u>	
DATE SIGNED <u>2/19/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb. 20, 1951</u>	<u>Brookview</u>	<u>Rising Sun, Md.</u>
24. FUNERAL DIRECTOR	ADDRESS		
<u>L. M. Morhington</u>	<u>P. O. 290116</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Mildred	(Middle) Eliza	(Last) Graybeal
4. DATE OF DEATH	Feb. 18	(Month)	(Day) 1951
5. SEX	Female	6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	Widowed	8. DATE OF BIRTH	Oct. 13, 1889
9. AGE last birthday	61 yrs.	10. KIND OF BUSINESS OR INDUSTRY	Housewife
11. BIRTHPLACE (State or foreign country)	Hemlock N.C.	12. CITIZEN OF WHAT COUNTRY	U.S.
13. FATHER'S NAME	Reeves Cox	14. MOTHER'S MAIDEN NAME	Eliza Martin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
		J. Winton Graybeal Rising Sun, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492x Immediate cause (a) _____
Antecedent cause(s) (b) _____
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

Coronary Thrombosis
Virus Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

10 minutes

4 weeks

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14, 1951, to Feb. 18, 1951, that I last saw the deceased alive on Feb. 18, 1951, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, or other disposal (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 22, 1951	West Nottingham	Near Coloma,	Md

DATE REC'D BY LOCAL REGISTRAR	SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 19, 1951	L. M. Northington	J. E. Tyson	Rising Sun, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1424 91

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Chesapeake		CITY (If outside corporate limits, write RURAL and give nearest town) Chesapeake	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chesapeake City		STREET ADDRESS (If rural, give location) Md	
3. NAME OF DECEASED (First) (Middle) (Last) Harry HERNICK		4. DATE OF DEATH (Month) (Day) (Year) Feb 25 1951	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb 4, 1910
9. AGE last birthday 41 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) Glen Burnie Pa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Nicholas HERNICK		14. MOTHER'S MAIDEN NAME Pauline HERNICK Sr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mary HERNICK Ches City, Md			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary thrombosis			5 minutes
Antecedent cause(s) (b) Cardiac Decompensation			3 months
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Valvular rheumatic heart disease			35 years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY m.			

22. I hereby certify that I attended the deceased from Feb 12, 1951, to Feb 28, 1951, that I last saw the deceased alive on Feb 27, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Funeral	Mar 3/51	St. Rose	Chesapeake City, Md
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 2-1951	Mrs. Russell A. Bell	W. H. Lippman & Son	Edmon, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105

RECEIVED
MAR 5 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1425

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perry Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Hospital</u>		STREET ADDRESS (If rural, give location) <u>7004 Park Heights Avenue</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>LOUIS</u> (First) <u>K.</u> (Middle) <u>KLINE</u> (Last)		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 16, 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mayer Kline - Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Name Unknown - Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, VAH, Perry Point, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH
Unknown

Immediate cause

(a) Coronary thrombosis

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary sclerosis, severe(c) Arteriosclerosis, generalized

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Dementia Praecox, Paranoid type

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12-10, 1925, to 2-1, 1951, that I have seen the deceasedalive and that death occurred at 6:20 am., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. 2-2-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>2-5-51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore, Md.</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
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DATE REC'D BY LOCAL REG. <u>Feb. 5, 1951</u>	REGISTRAR'S SIGNATURE <u>Doreen E. Daugherty</u>	24. FUNERAL DIRECTOR <u>Pennington & Son</u>	ADDRESS <u>Havre de Grace, Md.</u>
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PENNINGTON & SON, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

1426

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH - COUNTY <i>Sevier</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Ind.</i> COUNTY <i>Sevier</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ellettsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ellettsville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sevier Hospital</i>		STREET ADDRESS (If rural, give location) <i>124 Millburn St.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>MARGARET</i> (Middle) <i>EMMA</i> (Last) <i>MATTHEWS</i>	4. DATE OF DEATH	(Month) <i>2</i> (Day) <i>9</i> (Year) <i>1951</i>
5. SEX <i>Fi.</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH <i>1-21-1930</i>
9. AGE last birthday <i>21</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Ellettsville, Ind.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Williams</i>		14. MOTHER'S MAIDEN NAME <i> Helen Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Roy Matthews</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Lacerated liver dome.</i>			
Antecedent cause(s) (b) <i>5 inches in length. Cerebral</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Concussion injured kidney fractured ribs.</i>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>2-6-51</i>	19b. MAJOR FINDINGS OF OPERATION <i>Opening of abdomen. Lacerated liver.</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home 279</i>	CITY OR TOWN (COUNTY) (STATE) <i>Ellettsville Rural Sevier Ind</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2 6 51 1230 p.m.</i>	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>Auto. hit concrete abutment</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>Dr. W. L. Dodson MD DME</i>		DATE SIGNED <i>Sevier Ind 2-9-51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>2/13/51</i>	NAME OF CEMETERY OR CREMATORY <i>Shoemaker Cemetery</i>	
DATE REC'D BY LOCAL REG. <i>Feb 13</i>	REGISTRAR'S SIGNATURE <i>Edw R Bell</i>	24. FUNERAL DIRECTOR ADDRESS <i>1211 Dela</i>	

730869



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1427

1. PLACE OF DEATH: COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Wampum	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) JOHN (Middle) H. (Last) MC CUMMINS		4. DATE OF DEATH (Month) February 7 (Day) 19 (Year) 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 2, 1895
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT Country USA	
13. FATHER'S NAME James McCummins - Deceased		14. MOTHER'S MAIDEN NAME Olena McCummins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

421.4 Immediate cause (a) Acute Bacterial Endocarditis

12 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Calciferous Valvular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 29, 1932, to Feb. 7, 1951, that I last saw the deceased

alive on Nov. 29, 1932, and that death occurred at 3:45 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. T. BRADON, M.D., Chief, Professional Services, VAH, Perry Point, Md. 2-7-51

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-7-51	NAME OF CEMETERY OR CREMATORY Unknown	LOCATION (City, town, or county) New Castle, Pa.	(State)
DATE REC'D BY LOCAL REG. Feb. 7, 1951	REGISTRAR'S SIGNATURE Irene E. Langhelf	24. FUNERAL DIRECTOR Pennington & Son		ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1428

1. PLACE OF DEATH- COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		LENGTH OF STAY (in this place) <u>5 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
TOWN <u>Elkton</u>				TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elkton R.D. 5 Md</u>				STREET ADDRESS (If rural, give location) <u>RD 5</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>WILLIAM</u>		(Last) <u>Müller, Sr.</u>	
		(Middle) <u>Jacob</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 23 1951</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>Wh</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
				8. DATE OF BIRTH <u>Aug 22/1974</u>	
				9. AGE last birthday <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher for school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>	
13. FATHER'S NAME <u>Christian Müller</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u></u>		17. INFORMANT AND ADDRESS <u>Mrs. Ernest Müller, Elkton R.D. 5 Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>MALIGNANT Hypertension</u>					<u>3 yrs +</u>	
445X Antecedent cause(s) (b) <u>Arteriosclerosis</u>					<u>3 yrs +</u>	
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Bilateral Glaucoma</u>					<u>3 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS						
Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)			PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12 Nov., 1948, to 23 Feb., 1951, that I last saw the deceased alive on 21 Feb., 1951, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) George Kreis, Jr. M.D. ADDRESS Elkton, Md DATE SIGNED 2-23-51

23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>Feb. 26/51</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		LOCATION (City, town, or county) (State) <u>Phil Pa</u>	
DATE REC'D BY LOCAL REG. <u>Feb 23</u>		REGISTRAR'S SIGNATURE <u>J. K. Trauger</u>		24. FUNERAL DIRECTOR <u>H. W. Tappan & Son</u>		ADDRESS <u>Elkton Md</u>	

770 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Onancock	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) R.F.D. #1, Box 163	
3. NAME OF DECEASED (Type or Print) ROBERT O. PADDY		4. DATE OF DEATH (Month) (Day) (Year) February 23 19 51	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH March 18 90
9. AGE last birthday 60 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk.	10b. KIND OF BUSINESS OR INDUSTRY unk.	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Viola R. Paddy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point Md.	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
<p>956X Immediate cause (a) Peritonitis, diffuse, chemical due to</p> <p>129 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</p> <p>(b) Urinary leak about old cystotomy scar</p> <p>(c) Arteriosclerosis, generalized</p>	3 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 28, 19 37, to Feb. 23, 19 51, that I last saw the deceased

and that death occurred at 11:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E. S. ELLS, M.D. Act'g. Chief Professional Services, VAH Perry Point Md. 2/23/51

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2/24/51	NAME OF CEMETERY OR CREMATORY Unknown	LOCATION (City, town, or county) Taskey, Va.	(State)
DATE REC'D BY LOCAL REG. Feb. 24, 1957	REGISTRAR'S SIGNATURE Irene E. Dougherty	24. FUNERAL DIRECTOR Perryman & Son	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1430 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
TOWN Perry Point		TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 512-12th St., N.E.	
3. NAME OF DECEASED (Type or Print) GEORGE (First) H. (Middle) PERKINS (Last)		4. DATE OF DEATH February 22 (Month) 22 (Day) 1951 (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June 1, 1890
9. AGE last birthday 60 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		12. BIRTHPLACE (State or foreign country) New Hampshire	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Pneumonia bronchial, bilateral due to**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Pylonephritis bilateral**(c) **Abscess multiple prostatic**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis, generalized

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) HOMICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Sept. 27, 1939**, to **Feb. 22, 1951**, and that death occurred at **6:00 a.m.**, from the causes and on the date stated above.SIGNATURE **E. T. Brannon** (Degree or title) **Chief, Professional Services, VAH, Perry Point, Md.** ADDRESS **2-23-51** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 2-23-51		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) Baltimore, Md.		(State)	
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DATE REC'D BY LOCAL REG. **Feb. 23, 1951** REGISTRAR'S SIGNATURE **James E. Laughlin** GENERAL DIRECTOR **Pennington & Son** ADDRESS **Havre de Grace, Md.**

PENNINGTON & SON, Havre de Grace, Md. 690488

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1431

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton P.D. 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Elkton P.D. (Glasgow Road)		STREET ADDRESS Glasgow Road	
3. NAME OF DECEASED (Type or Print) Frieda Ramsauer		4. DATE OF DEATH (Month) Feb. (Day) 14 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Mar 23/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 59 yrs.
11. BIRTHPLACE (State or foreign country) Germany Switzerland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jacob Pies		14. MOTHER'S MAIDEN NAME Mrs. J. Pies	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Leonard Ramsauer.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
416x Immediate cause (a)	Acute Coronary Occlusion		Inst.
95b Antecedent cause(s) (b)	Rheumatic Heart Disease		15 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 9, 1951, to Feb 14, 1951, that I last saw the deceased alive on Feb. 13, 1951, and that death occurred at 10:15 a.m., from the causes and on the date stated above.

SIGNATURE Dr. E. H. Sprecher, M.D.	(Degree or title)	ADDRESS 228 E. 7th St.	DATE SIGNED Feb. 17, 1951
23. BURIAL, CREMATION REMOVAL (Specify)	DATE Feb 17/51	NAME OF CEMETERY OR CREMATORY Glasgow Memorial Pk	LOCATION (City, town, or county) (State) Elkton Md
DATE REC'D BY LOCAL REG. Feb 17	REGISTRAR'S SIGNATURE H. H. Hager	24. FUNERAL DIRECTOR R. W. Puffer & Son	ADDRESS Elkton, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Ches City Md		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Ches City Md	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chesapeake City P.D.		STREET ADDRESS (If rural, give location) Chesapeake City P.D. Md.	
3. NAME OF DECEASED (First) Harry (Middle) McKee (Last) Roberts		4. DATE OF DEATH (Month) Feb. (Day) 25 (Year) 1951	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 15, 1878
9. AGE last birthday 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Md.)	
11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Roberts.		14. MOTHER'S MAIDEN NAME Laura Davis.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT Mr. James Roberts, Ches. City, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) acute cardiac dilatation		4 hrs.
Antecedent cause(s) (b) Chronic myocarditis		2 mos.
(c) Cerebral embolism		1 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		none
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 15th, 1951, to Feb 25th, 1951, that I last saw the deceased alive on Feb 23rd, 1951, and that death occurred at 7:00 a.m., from the causes and on the date stated above.

SIGNATURE	DATE SIGNED			
James J. McQuinn M.D.	Feb 25 1951			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 21/51	Bethel	Chesapeake City P.D. Md.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 28 - 1951	Wm. B. Balfour H. Pull	Whittemore & Son	Elkton, Md.

930746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1438 92

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) ELKTON		CITY (If outside corporate limits, write RURAL and give nearest town) ELKTON	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 266 W. Main		STREET ADDRESS (If rural give location) 266 W. Main St.	
3. NAME OF DECEASED (Type or Print)	(First) Walter	(Middle) Rothwell	(Last)
5. SEX M	6. COLOR OR RACE W. H. G.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH June 1, 1923
9. AGE last birthday 29 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Septic	10b. KIND OF BUSINESS OR INDUSTRY Septic Worker	11. BIRTHPLACE (State or foreign country) Elkton Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME No	14. MOTHER'S MAIDEN NAME Lillian Rothwell	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. 217-18-1537	17. INFORMANT Mrs Lillian Reibert		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH 9 yrs.
Immediate cause (a) Pneumatic Heart Disease			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 11, 1950, to Feb. 9, 1951, that I last saw the deceased alive on Feb. 9, 1951, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE Dr. N. Schneider M.D.	(Degree or title)	ADDRESS Elkton	DATE SIGNED Feb. 9, 1951
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 11, 1951	NAME OF CEMETERY OR CREMATORY Elkton Cemetery	LOCATION (City, town, or county) Elkton Md.
DATE REC'D BY LOCAL REG. Feb 10	REGISTRAR'S SIGNATURE F. S. Rager	24. FUNERAL DIRECTOR H. W. Pappert Son	ADDRESS Elkton Md.

007439

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1434

1. PLACE OF DEATH- COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Liberty Grove		LENGTH OF STAY (in this place) 53 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Liberty Grove			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)		
Lula		Pusey	Rowland	Feb. 8			1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
Female	White	Widowed		Oct. 5, 1874		76 Yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Own Home		Port Deposit Md.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lewis D. Pusey				Addaliza Knight			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
no						Wessels Pusey Colora, Md. R.D.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Cerebral Hemorrhage	9 days
Antecedent cause(s) (b)	Paralysis Rt. Side.	10 yrs
(c)	Arterio-sclerotic Hypertension	10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 29, 1951, to Feb 7, 1951, that I last saw the deceased alive on Feb 7, 1951, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE B. Henson, M.D. ADDRESS Port Deposit, Md. DATE SIGNED 2/9/51

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial		Feb. 11, 1951	West Nottingham	Near Colora	Md.
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS
Feb 9-51		W. Nottingham	J. E. Tyson		Rising Sun, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1435

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) Minerva V. Rutter		4. DATE OF DEATH (Month) (Day) (Year) Feb. 27, 1951 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1-16-1870
9. AGE last birthday 81 yrs.		10. If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Lynch		14. MOTHER'S MAIDEN NAME Lenora Benjamin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs Edwin Williams, Port Deposit, md			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.2 Immediate cause (a) Chronic Myocarditis.		5 yrs
93d Antecedent cause(s) (b) Pulmonary Congestion.		3 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov-20, 1950, to Feb 27, 1951, that I last saw the deceased alive on Feb 27, 1951, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE B. J. Johnson, M.D. ADDRESS Port Deposit, Md. DATE SIGNED 2/28/51.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3-2-1951	NAME OF CEMETERY OR CREMATORY Hopewell	LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
DATE REC'D BY LOCAL REG. Feb 28, 1951	REGISTRAR'S SIGNATURE James E. Dougherty	24. FUNERAL DIRECTOR L. A. Patterson & Son	ADDRESS Perryville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1436 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 307 T. Street, N.W.	
3. NAME OF DECEASED (First) JESSE (Middle) P. (Last) SHANKLE	4. DATE OF DEATH (Month) February (Day) 15 (Year) 1951		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 8, 1908
9. AGE last birthday 42 yrs.		10. BIRTHPLACE (State or foreign country) North Carolina	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Shankle - Deceased		14. MOTHER'S MAIDEN NAME Annie Goiro - Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Bronchial pneumonia, bilateral due to

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cirrhosis of the liver

(c) Anasarca

INTERVAL BETWEEN ONSET AND DEATH

48 hours

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work Not While at Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 24, 1951, to Feb. 15, 1951, that I last saw the deceased

alive on Jan. 24, 1951, and that death occurred at 10:35 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. P. BRANNON, M.D.

Chief, Professional Services, VAH, Perry Point, Md. 2-16-51

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE THEREOF 2-16-51

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) Fort Myer, Virginia

(State)

DATE REC'D BY LOCAL REG. Feb. 16, 1951

REGISTRAR'S SIGNATURE Irene E. Dougherty

24. FUNERAL DIRECTOR

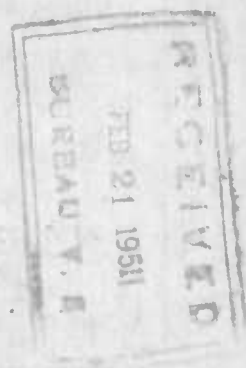
ADDRESS

PENNINGTON & SONS, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1437

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN North East		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN North East	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Robert H. (First) (Middle) (Last) Sipp		4. DATE OF DEATH (Month) 2 (Day) 1 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-28-1872
9. AGE last birthday 78 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Penna R.R.	
11. BIRTHPLACE (State or foreign country) Philadelphia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Sipp		14. MOTHER'S MAIDEN NAME no information	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 717-07-5361	
17. INFORMANT Mrs Bessie M. Sipp			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
442x Immediate cause (a) <u>Pulmonary Edema</u>	<u>3 hours</u>
131a Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Renal Disease</u>	<u>4 years</u>
(c) _____	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May, 1946, to 1 Feb, 1951, that I last saw the deceased alive on 1 Feb, 1951, and that death occurred at 11:15 P.m., from the causes and on the date stated above.

SIGNATURE Klaus H. Fischer M.D. ADDRESS North East, Md DATE SIGNED 2 Feb '51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2-8-1951	NAME OF CEMETERY OR CREMATORY Methodist	LOCATION (City, town, or county) North East, Cecil Md.
DATE REC'D BY LOCAL REG. 2-4-51	REGISTRAR'S SIGNATURE <u>Sarah E. Rothmel</u>	24. FUNERAL DIRECTOR <u>Joseph R. Grant</u>	ADDRESS <u>North East, Md.</u>

690516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1951
BUREAU OF AERONAUTICS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE NEW JERSEY COUNTY ATLANTIC	
CITY (If outside corporate limits, write RURAL and give nearest town) PERRY POINT,		CITY (If outside corporate limits, write RURAL and give nearest town) ATLANTIC CITY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural, give location) 116 S. MASSACHUSETTS AVENUE.	
3. NAME OF DECEASED (Type or Print) WILLIAM H. SPAYD		4. DATE OF DEATH (Month) February (Day) 24 (Year) 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 4-10-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) PALMYRA, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W. SPAYD		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 204-05-7275	
17. INFORMANT AND ADDRESS Hospital Records, VAH., Perry Point, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH
Unknown

Immediate cause

(a) **Coronary Thrombosis.**

Antecedent cause(s)

(b) **Coronary Sclerosis**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **Arteriosclerosis, general.**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **June 15, 1950**, to **Feb. 24, 1951**, that I last saw the deceased **Feb. 24, 1951**, and that death occurred at **1:15 AM** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

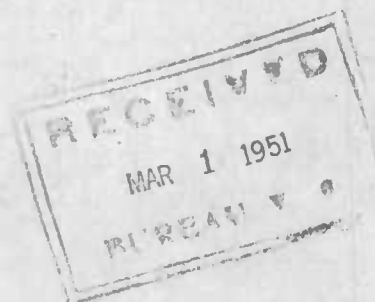
DATE SIGNED

E. P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md. 2-26-51	
23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	DATE THEREOF 2/26/51
NAME OF CEMETERY OR CREMATORY Beverly National Cemetery	LOCATION (City, town, or county) (State) Beverly, New Jersey
DATE REC'D BY LOCAL REG. Feb. 26, 1951	REGISTERAR'S SIGNATURE James E. Dougherty
24. FUNERAL DIRECTOR PENNINGTON & SON, Havre De Grace, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1439

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <u>Becil</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Ind.</u> COUNTY <u>Becil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>JAMES</u> (Middle) <u>OSCAR</u> (Last) <u>STANLEY</u>	4. DATE OF DEATH (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1957</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Single</u>	8. DATE OF BIRTH <u>10-8-1944</u> 9. AGE last birthday <u>12</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James Oscar Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Estep</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>Martha Stanley</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

780.2 Immediate cause (a) Convulsions
 Antecedent cause(s) (b) cause undetermined
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE Dr. R. E. Rodden D.M.E. ADDRESS Wilmington, Ind. DATE SIGNED 2-16-57

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>Feb. 19/57</u>	NAME OF CEMETERY OR CREMATORY <u>Gulpen Manor M. Pk.</u>	LOCATION (City, town, or county) <u>Elkton, Ind.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb 19</u>	REGISTRAR'S SIGNATURE <u>H. B. Trauer</u>	24. FUNERAL DIRECTOR <u>H. W. Appen & Son</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1440

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <u> Cecil </u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u> Pa. </u> COUNTY <u> Philadelphia </u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u> Enroute to Wash. </u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u> Philadelphia </u>	
TOWN <u> </u>		TOWN <u> </u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u> Exton </u>		STREET ADDRESS (If rural give location) <u> 665 N. 41 St. </u>	
3. NAME OF DECEASED (First) <u> MAMIE </u> (Middle) <u> </u> (Last) <u> STREET'S </u>		4. DATE OF DEATH (Month) <u> 2 </u> (Day) <u> 8 </u> (Year) <u> 1951 </u>	
5. SEX <u> F. </u>	6. COLOR OR RACE <u> Col. </u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u> Married </u>	8. DATE OF BIRTH <u> July 25 - 1896 </u>
9. AGE last birthday <u> 54 </u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u> If under 24 hrs. Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (State or foreign country) <u> King & Queen Co. Pa. </u>		12. CITIZEN OF WHAT COUNTRY <u> U.S.A. </u>	
13. FATHER'S NAME <u> Edwin L. Hill </u>		14. MOTHER'S MAIDEN NAME <u> Mattie Holmes </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> no </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> - </u>	
17. INFORMANT <u> Eleanor Hill Gleason </u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u> 420.1 Immediate cause Acute Coronary Thrombosis </u>		
(b) <u> 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last </u>		
(c) <u> </u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u> Removal </u>	DATE THEREOF <u> Feb 8 </u>	NAME OF CEMETERY OR CREMATORY <u> Bethlehem Cemetery </u>	LOCATION (City, town, or county) (State) <u> King & Queen Co. Va. </u>
DATE REC'D BY LOCAL REG. <u> Feb 8 </u>	REGISTRAR'S SIGNATURE <u> J. H. Frazar </u>	24. FUNERAL DIRECTOR <u> H. W. Pippin </u>	ADDRESS <u> Exton, Md. </u>

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>SUSANNA</u>	(Middle) <u>S</u>	(Last) <u>STRIMEL</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Aug 18 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>75</u> yrs.
13. FATHER'S NAME <u>ELI STRIMEL</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN REYNOLDS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT <u>Herman Furlock</u>	
16. SOCIAL SECURITY No.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u>	(a) <u>Coronary Thrombosis</u>	<u>12 hrs.</u>
Antecedent cause(s) <u>131a</u>	(b) <u>Hypertensive Cardiovascular Renal Disease</u>	<u>10 years</u>
	(c) <u>Hypertrophic Arthritis</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF ~ office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1946, to 18 Feb., 1951, that I last saw the deceased alive on 18 Feb., 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE Klaus H. Thuermer M.D. ADDRESS North East Md DATE SIGNED 19 Feb '51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>3 weeks</u>	<u>2-21-51</u>	<u>Methodist</u>	<u>North East</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2-19-51</u>	<u>Sarah C. Rothermel</u>	<u>Joseph R. Lauer</u>	<u>North East Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



The correct age in 9 shown on: Evidence for change in 9 shown on: MARYLAND STATE DEPARTMENT OF HEALTH 2411 N. Charles Street, Baltimore

Evidence for change in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 130 FEB 19 1951

CERTIFICATE OF DEATH

1442 96
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Wasingnton, D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) 1231 Kearny St., N.E. Washington, D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) Albert (Middle) L (Last) SUMNER		4. DATE OF DEATH (Month) Feb. (Day) 10 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep	8. DATE OF BIRTH 6-5-1909
9. AGE last birthday 18 yrs. 4 mos. 10 days		10. BIRTHPLACE (State or foreign country) Washington, D.C.	
11. FATHER'S NAME Unknown		12. MOTHER'S MAIDEN NAME Mrs. Ada Sumner	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. SOCIAL SECURITY No.	
15. INFORMANT AND ADDRESS		16. CITIZEN OF WHAT COUNTRY USA	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

445x Immediate cause (a) Malignant Hypertension

Antecedent cause(s)

102 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 12-21, 1948, to 2-10 P.M., 1951, that I last saw the deceased alive on 2-10 P.M., 1951 and that death occurred at 7:50 P.M., from the causes and on the date stated above.

SIGNATURE

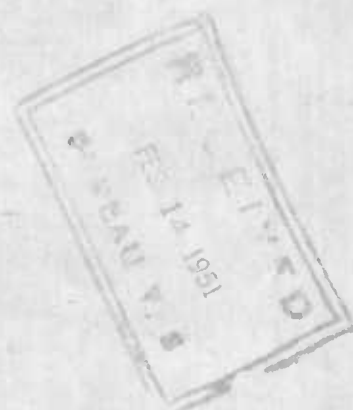
(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-11-51	NAME OF CEMETERY OR CREMATORY Mount Hope Cem	LOCATION (City, town, or county) Washington, D.C.	(State)
DATE REC'D BY LOCAL REG. 2-11-51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Montgomery (Bro)	ADDRESS 913 Florida Ave, N.W. Washington, D.C.	

Montgomery Bros. L. B. Montgomery



95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County Blue Ball Rural-Elkton, Md.
 City or town Blue Ball (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs.
 Hospital, institution, or street address where death occurred: Blue Ball
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Cecil
 City or town Elkton (rural) (If outside city or town limits, write RURAL and give nearest town)
 Street No. Blue Ball (rural)
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Elijah Williams

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Jennive Williams
 6. (c) If alive, give age 57 1/2 yrs.
 7. Birth date of deceased (mo., day, yr.) July 15, 1893
 8. AGE: Years 57 Months 7 Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)
 10. Usual occupation Farm Work
 11. Industry or business Moore Rest Home
 FATHER 12. Name Elijah Williams
 13. Birthplace Md.
 MOTHER 14. Maiden name Laura
 15. Birthplace Md.

16. Informant Jennive Williams
 Address Elkton Md. R. 5 (Blue Ball)
 Burial Feb. 28, 1951
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Trinity Cem.
 Location Zion Maryland
 18. Funeral director Edw R Bell
 Address 909 Poplar St., Wilm. Del.
 19. Feb 28 1951 JR Frager Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1951 at 9:40 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1951 to Feb 23 1951
 and that I last saw him alive on Feb. 22 1951
 Immediate cause of death Lobar pneumonia
 Due to Bronchitis
 Due to
 Other conditions Cardiac
490 Gout (Include pregnancy within 8 months of death)
 108
 Major findings of operations none
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

5 day

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE James S. Johnson M.D.
 Address Elkton, Md. Date signed 2/16/51
970 868

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1951
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1445

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md</u>	
TOWN <u>Union</u>		TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hosp.</u>		STREET ADDRESS (If rural give location) <u>317 Curtis Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rodney Newman Wyatt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 13 1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 13/51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday (If under 1 year Months Days Hours Min.) <u>19.5</u>
11. BIRTHPLACE (State or foreign country) <u>Elkton, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jack Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>Sola Webbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Jack Wyatt, 317 Curtis Ave.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Failing of Corone of Foramen Oval 1/2 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) none

(c) none

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-13-51 5:20 p.m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>		

22. I hereby certify that I attended the deceased from 2-13-51 1951, to 2-13- 1951, that I last saw the deceased

alive on 2-13- 1951, and that death occurred at 5:20 p.m. from the causes and on the date stated above.

SIGNATURE Carl Rosenwald MD ADDRESS Elkton Md DATE SIGNED 2/14/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Feb 14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	LOCATION (City, town, or county) <u>Elkton, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb 14</u>	REGISTRAR'S SIGNATURE <u>F. H. Hagan</u>	24. FUNERAL DIRECTOR <u>Howe & Son</u>	ADDRESS <u>Elkton Md</u>	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 10 1951
BUREAU OF AERONAUTICS